FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041871

Facility Name: Provena St Joseph Center

Address: 659 e. Jefferson (Number) Freeport (City) 61032 (Zip Code)

County: Stephenson

Telephone Number: (815) 232-6181 **Fax #** (815) 232-6143

IDPA ID Number: 37-1127787011

Date of Initial License for Current Owners: 07/01/96

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	503(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cassie Kross **Telephone Number:** (815) 928-6860

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from _____ to _____ and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Brent Shear

(Title) VP-Finance Provena Senior Services

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	140		2,184	2,324	8
9	SNF/PED					9
10	ICF	17,070	22,559		39,629	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,210	22,559	2,184	41,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.52%

D. How many bed-hold days during this year were paid by Public Aid?
243 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
n/a

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 07/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 07/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,184

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** **Ending:**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	257,873	31,783	11,900	301,556		301,556	(451)	301,105			1
2	Food Purchase		226,157		226,157		226,157	(110,331)	115,826			2
3	Housekeeping	91,774	8,709		100,483		100,483		100,483			3
4	Laundry	100,794	13,064	12,943	126,801		126,801	(102)	126,699			4
5	Heat and Other Utilities			128,907	128,907		128,907		128,907			5
6	Maintenance	76,670	12,972	19,483	109,125		109,125		109,125			6
7	Other (specify):*											7
8	**TOTAL General Services**	527,111	292,685	173,233	993,029		993,029	(110,884)	882,145			8
	B. Health Care and Programs											
9	Medical Director			4,845	4,845		4,845		4,845			9
10	Nursing and Medical Records	1,575,780	212,526	416,458	2,204,764		2,204,764	(382,071)	1,822,693			10
10a	Therapy											10a
11	Activities	47,105	1,008	4,455	52,568		52,568	(864)	51,704			11
12	Social Services	58,264	98	1,191	59,553		59,553	(72)	59,481			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Pastoral Care**	14,996	538	24	15,558		15,558		15,558			15
16	**TOTAL Health Care and Programs**	1,696,145	214,170	426,973	2,337,288		2,337,288	(383,007)	1,954,281			16
	C. General Administration											
17	Administrative	60,439		461,210	521,649		521,649	(461,210)	60,439			17
18	Directors Fees											18
19	Professional Services			32,988	32,988		32,988		32,988			19
20	Dues, Fees, Subscriptions & Promotions			7,105	7,105		7,105	(1,595)	5,510			20
21	Clerical & General Office Expenses	77,835	4,884	103,166	185,885		185,885	112,596	298,481			21
22	Employee Benefits & Payroll Taxes			419,454	419,454		419,454	37,914	457,368			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,865	6,865		6,865		6,865			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):* **Fundraising**	23,864	611	6,974	31,449		31,449	(31,449)				27
28	**TOTAL General Administration**	162,138	5,495	1,037,762	1,205,395		1,205,395	(343,744)	861,651			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,385,394	512,350	1,637,968	4,535,712		4,535,712	(837,635)	3,698,077			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena St Joseph Center #0041871 **Report Period Beginning:** **Ending:**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			151,031	151,031		151,031		151,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							254,139	254,139			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			151,031	151,031		151,031	254,139	405,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,880	65,880		65,880		65,880			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,385,394	512,350	1,854,879	4,752,623		4,752,623	(583,496)	4,169,127			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** **Ending:**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(110,331)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,500)	21		24
25	Fund Raising, Advertising and Promotional	(1,595)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(31,449)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (163,875)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(31,379)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (31,379)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (195,254)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs	x		379,108	10	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 379,108		47

STATE OF ILLINOIS

Provena St Joseph Center

ID# 0041871

Report Period Beginning:

Ending:

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
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67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** **Ending:**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(110,331)	0	0	0	0	0	0	0	0	0	0	(110,331)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(110,331)	0	0	0	0	0	0	0	0	0	0	(110,331)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(323,432)	0	0	0	0	0	0	0	0	0	(323,432)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,595)	0	0	0	0	0	0	0	0	0	0	(1,595)	20
21	Clerical & General Office Expenses	(20,500)	0	0	0	0	0	0	0	0	0	0	(20,500)	21
22	Employee Benefits & Payroll Taxes	0	37,914	0	0	0	0	0	0	0	0	0	37,914	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,095)	(285,518)	0	0	0	0	0	0	0	0	0	(307,613)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,426)	(285,518)	0	0	0	0	0	0	0	0	0	(417,944)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Provena St Joseph Center** **#** **0041871** **Report Period Beginning:** **Ending:**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**254,139**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**254,139**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**254,139**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**254,139**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(132,426)**	**(31,379)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(163,805)**	**45**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Provena Senior Services	100	See Attached				
Provena Health						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 461,210	Provena Senior Services -salaries		$ 137,778	$ (323,432)	1
2	V	22			-benefits		37,914	37,914	2
3	V	32			-interest		254,139	254,139	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 461,210			$ 429,831	$ * (31,379)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	n/a								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		n/a				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Provena Health	X		Mortgage/Land	$25,780.90	04/01/99	$ 4,300,000	$ 4,205,466	03/01/29	6.00%	$ 254,139	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$25,780.90		$ 4,300,000	$ 4,205,466			$ 254,139	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,300,000	$ 4,205,466			$ 254,139	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** **Ending:**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,080 B. General Construction Type: Exterior Brick Frame Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

St. Vincent Adult Day Care
St. Vincent Community Living Facility-Housing for 20 Developmentally Disabled Adults
St. Vincent Supportive Living Arrangement-Support for DD Residents in the Community

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1996	$ 1,400,000	1
2					2
3	TOTALS			$ 1,400,000	3

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996	1994	$ 2,500,000	$ 62,500	40	$ 62,500	$	$ 281,250	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	3 Pc. Shower			2000	567	41	7	41		41	9
10	Boiler/Steam Leak Fix			2000	2,267	227	5	227		231	10
11	HVAC Unit			2000	1,917	192	5	192		192	11
12	Common Area Assessment			2000	3,807	381	5	381		381	12
13	Major Building Consulting			2000	5,712	286	10	286		286	13
14	Roof-O'Niel Hall Archive Room			2000	1,290	129	5	129		129	14
15	Excavating			2000	1,605	161	5	161		161	15
16	Sealcoat Asphalt			2000	4,729	473	5	473		473	16
17											17
18	Air Conditioning CLF			1999	44,536	2,226	20	2,226		3,339	18
19	Air Conditioning Unit			1999	20,312	2,032	10	2,032		3,048	19
20	Carpeting			1999	2,077	416	5	416		624	20
21	Restroom Remodeling			1999	14,001	1,400	10	1,400		2,100	21
22	Handicapped Accessible Bathrooms			1998	3,718	372	10	372		931	22
23	Carpeting			1998	3,100	1,033	3	1,033		2,583	23
24	Underground Storage Tank Removal			1997	17,030	1,135	15	1,135		3,973	24
25	Carpeting			1997	8,906	1,781	5	1,781		6,235	25
26	Grind & Tuckpointing			1997	4,000	800	5	800		2,800	26
27	Change Piping on Hot Water Boilers			1997	1,037	207	5	207		725	27
28	Compressor and Motor			1997	1,034	207	5	207		724	28
29	Repair A/C Units			1997	1,357	271	5	271		949	29
30	Compressor and Motor			1997	1,784	357	5	357		1,249	30
31	Boiler Repair			1996	3,510	351	10	351		1,229	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,648,296	$ 76,978		$ 76,978	$	$ 313,653	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 500,410	$ 65,900	$ 65,900	$	3-10	$ 226,354	37
38	Current Year Purchases	69,486	3,400	3,400		5-10	3,400	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 569,896	$ 69,300	$ 69,300	$		$ 229,754	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Transport	199 Dodge Van	1999	$ 25,800	$ 1,820	$ 1,820	$	8	$ 4,837	42
43		1997 Dodge 2500	1997	24,090	2,409	2,409		5	16,863	43
44		Ford Falcon	1998	5,000	166	166		3	4,167	44
45		Chevrolet Bus	2000	5,008	358	358		7	358	45
46	TOTALS			$ 59,898	$ 4,753	$ 4,753	$		$ 26,225	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,678,090	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 151,031	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 151,031	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 569,632	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		n/a						5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	n/a	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** **Ending:**

XV. BALANCE SHEET - Unrestricted Operating Fund. As of _____ **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 4,242,543	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 736,233)		9,221,043	3
4	Supply Inventory (priced at Cost)		451,930	4
5	Short-Term Investments			5
6	Prepaid Insurance		18,282	6
7	Other Prepaid Expenses		220,967	7
8	Accounts Receivable (owners or related parties)		110,881	8
9	Other(specify): **This balance sheet is for Provena Senior Services**		603,895	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 14,869,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		6,504,791	12
13	Land		7,853,836	13
14	Buildings, at Historical Cost		68,287,725	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		11,695,959	16
17	Accumulated Depreciation (book methods)		(29,770,402)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,199,632	22
23	Other(specify): Goodwill(net)		3,926,223	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 69,697,764	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 84,567,305	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,500,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		548,703	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		2,162,467	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		245,211	32
33	Accrued Interest Payable		19,755	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36			340,968	36
37			(70,512)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 4,747,302	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		44,952,248	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self Ins Liabilty		104,327	43
44	Other		67,748	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 45,124,323	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 49,871,625	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 34,695,680	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 84,567,305	48

***(See instructions.)**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 32,057,986	1
2	Restatements (describe):		2
3	1999 Audit Adjustments	(27,746)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,030,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,887,291	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,887,291	17
	B. Transfers (Itemize):		
18	Transfers from Home Office	(45,939)	18
19	Unrealized Gain (Loss)	(175,912)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (221,851)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 34,695,680	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,220,358	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,220,358	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	185,056	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 185,056	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	110,331	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	424,461	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 534,792	23
	D. Non-Operating Revenue		
24	Contributions	125,383	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 125,383	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,065,589	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	993,029	31
32	Health Care	2,337,288	32
33	General Administration	1,205,395	33
	B. Capital Expense		
34	Ownership	151,031	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,752,623	40
41	**Income before Income Taxes (line 30 minus line 40)****	312,966	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 312,966	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,848	2,040	$ 44,068	$ 21.60	1
2	Assistant Director of Nursing	1,852	2,040	38,366	18.81	2
3	Registered Nurses	18,808	20,232	340,963	16.85	3
4	Licensed Practical Nurses	16,337	18,187	257,684	14.17	4
5	Nurse Aides & Orderlies	81,523	87,646	823,347	9.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,867	4,450	41,069	9.23	8
9	Activity Director	1,921	2,067	20,821	10.07	9
10	Activity Assistants	3,398	3,592	26,284	7.32	10
11	Social Service Workers	4,807	5,428	58,264	10.73	11
12	Dietician					12
13	Food Service Supervisor	2,085	2,080	30,670	14.75	13
14	Head Cook	2,085	2,249	22,367	9.95	14
15	Cook Helpers/Assistants	8,397	8,993	73,301	8.15	15
16	Dishwashers	18,202	19,450	131,535	6.76	16
17	Maintenance Workers	7,082	7,637	76,670	10.04	17
18	Housekeepers	11,127	12,075	91,774	7.60	18
19	Laundry	11,557	12,979	100,794	7.77	19
20	Administrator	2,120	1,796	60,439	33.65	20
21	Assistant Administrator					21
22	Other Administrative	1,916	2,080	23,140	11.13	22
23	Office Manager	1,660	2,080	24,691	11.87	23
24	Clerical	3,338	3,680	30,004	8.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,387	3,710	30,283	8.16	31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Fundraisi	2,860	3,214	38,860	12.09	33
34	TOTAL (lines 1 - 33)	210,177	227,705	$ 2,385,394 *	$ 10.48	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	238	$ 11,440	L1C3	35
36	Medical Director	404/month	4,845	L9C3	36
37	Medical Records Consultant	63	2,284	L10C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	1,547	L11C3	44
45	Social Service Consultant	22	771	L12C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	373	$ 20,886		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	83	$ 3,730	L10C3	50
51	Licensed Practical Nurses	761	17,511	L10C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	844	$ 21,241		53

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Rimkus	Administrator	0	$ 60,439
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,439

B. Administrative - Other

Description	Amount
Management Fees	$ 461,210
TOTAL (agree to Schedule V, line 17, col. 3)	$ 461,210
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Provena Health	MIS Fees	$ 14,064
Stickler & Nelson	Legal Fees	9,313
Barmann,Karamer & Bohlen	Legal Fees	866
Brittain & Ketchum	Legal Fees	5,213
Brian Hill	Admin Consult	1,329
Management Professionals	Admin Consult	350
RGB Architechtual Group	Admin Consult	1,174
Tln Partners	Admin Consult	680
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,988

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,777
Unemployment Compensation Insurance	6,000
FICA Taxes	173,708
Employee Health Insurance	122,995
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Ins	21,230
Vision Ins	3,269
Life Ins	12,795
Disability Ins	11,289
Pension	27,933
Other	4,458
Related Party	37,914
TOTAL (agree to Schedule V, line 22, col.8)	$ 457,368

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	212
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising	1,595
Books, Dues & Subs	5,298
Less: Public Relations Expense	( )
Non-allowable advertising	(1,595)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,510

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	781
Seminar Expense	6,084
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,865

**See instructions.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	n/a												
3													
4													
5													
6													
7													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** **Ending:**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? no

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Life Services Network $

(3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,880
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ n/a Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: KPMG Peat Marwick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Report being compiled

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.